STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. BUILDING 00 B. WING	10/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBROOKE REHABILITATION CENTRE & SUITES	990 N 16TH ST NEW CASTLE, IN47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00097672. This visit was done in conjunction with the Post Survey Revisit to the Investigation of Complaint IN00094307 completed on 8-19-11. Complaint IN00097672 - Substantiated. Federal/state deficiencies related to the allegations are cited at F252 and F9999. Survey date: October 4, 2011 Facility number: 000080 Provider number: 155160 AIM number: 100289330 Survey team: Angel Tomlinson RN TC Leslie Parrett RN Census bed type: SNF/NF: 70 Total: 70 Census payor type: Medicare: 9 Medicaid: 53 Other: 8 Total: 70	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Sample: 3 Stonebrooke Rehabilitation Centre was found to be in substantial compliance with 42 CFR Part 483 Subpart B in regard to the Investigation of Complaint IN00097672. This deficiency also reflects state findings cited in accordance with 410 IAC 16.2. Quality review 10/07/11 by Suzanne Williams, RN			
F0252 SS=A	The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview, the facility failed to maintain a bathroom ceiling in a clean manner, regarding the ceiling tile having brown and black substance on it, in 1 of 24 bathrooms observed during initial tour of the facility (bathroom #114). Finding include: During initial tour observation of the facility on 10-4-11 at 11:00 a.m., restroom #114 had a ceiling tile with brown and black staining on it. Interview on 10-4-11 at 3:00 p.m. with the	F0252	Submission of this Plan of Correction does not constitute an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this Plan of Correction as our credible allegation of compliance as of October 18, 2011. F 252 - The facility must provide a safe clean environment , allowing the resident to use his or her personal belongings to the extent possible. 1) Resident A ceiling tile in bathroom was replaced prior to survey exit. 2) Residents who reside in the facility have the	10/18/2011

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	Maintenance Supervisor indicated he agreed the ceiling tile in restroom #114 had brown and black substance on it. The Maintenance Supervisor removed the ceiling tile at that time and indicated it appeared the drain above the ceiling tile had been repaired. This federal deficiency relates to complaint IN00097672. 3.1-19(f)		potential to be affected by the alleged deficient practice. All resident rooms / bathrooms have been inspected for safe , clean , comfortable environment staff educated on Maintenance requisition on 10/18/11 . 3) Daily Maintenance rounds per policy will be conducted daily to ensure environment safe / clean / appropriate. Weekly safety rounds per SDC to be completed. All staff educated per Inservice on 10/18/11 by SDC on utiliziung Maintenance Requisitions to identify areas of concern and in need of Maintenance attention. 4) Environmental Maintenace requisitions to be reviewed by Executive Director for completion during facilities monthly safety meeting. Safety rounds reported monthly during safety meeting and during facility monthly CQI meeting. 5) The corrections will be completed by October 18, 2011.	
F9999	STATE FINDING: 3.1-13 ADMINISTRATION The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of	F9999	Submission of this Plan of Correction does not constitute an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. Please accept this Plan of Correction as our credible allegation of compliance as of October	10/18/2011

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	the administrator shall include, but are not limited to, the following: Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including but not limited to, any: epidemic outbreaks; poisonings; fires; or major accidents. If the department cannot be reached, such as on holidays or weekends, a call shall be made to the emergency telephone number ([317] 383-6144) of the division. This state rule was not met as evidenced by: Based on observation, record review and interview, the facility failed to report to the Department of Health, the facility's building foundation sinking, resulting in the floor to resident rooms to be uneven in the interior right corner of the rooms in the northeast hallway of the facility, for 12 of 12 bedrooms observed (bedroom #135, #133, #131, #129, #127, #125, #123, #121, #119, #233, #231 and #229) in the northeast hallway. Finding include:		17,2011. 410 IAC 16.2-5-1.3 Administration and Management : 1)On October 14, 2011 it was reported to the ISDH that Stonebrooke Rehab Centre had experienced some settling to some resident rooms by the Executive Director. No residents who reside in the facility were directly affected by the alleged deficient practice. 2) No other residents who reside in the faciility have the potrential to be affected by the alleged deficient practice. 3) In the event of a potential unuusual occurrence IDT members will meet and review available information related to potential occurrence - Risk Management - Resident and Visitor Unusual Occurrence policy will be utilized in determining if criteria of reporting is identified. If determined reportable , initial reporting will be completed within 24 hours and follow up completed within 5 days of Unusual Occurrence. Any incident of structural damage will be reported immediately to the ISDH by the Executive Director. 4)Executive Director will review and Inservice Risk Management - Resident and Visitor Unusual Occurrence policy with IDT members by 10/17/11 (See attachment #3). Discuss / review concerns and State reportables monthly during facility's CQI meeting to ensure that they are meeting state guidelines. 5) The corrective actions will be	

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	Interview with the Administrator on 10-4-11 at 11:15 a.m., indicated on 9-23-11 the facility staff reported to him that the floors in resident bedrooms had significantly settled and the corners of the bedrooms were tilted. The Administrator indicated the facility immediately moved residents from the bedrooms most effected. The Administrator indicated the facility did not report the situation to the Department of Health. During observation with the Administrator on 10-4-11 beginning at 11:42 a.m., bedrooms #135, #133, #131, #129, #127, #125, #123, #121, #119, #233, #231 and #229 had a downward slope in the right corner of the rooms. The policy for "Risk Management-Resident and Visitor Unusual Occurrences," provided by the Administrator on 10-4-11 at 2:25 p.m., indicated " An occurrence/event is defined as any happening not consistent with the routine operation of the nursing facility, which may have caused or may have the potential for causing injury to residents, visitors, or loss or damage of property." The events were required to be reported the Department of Health within 24 hours of the occurrence and followed by a written report within 5 days of the		completed on or before October 17, 2011.	

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	occurrence. This state finding relates to complaint IN00097672. 3.1-13(g)(1)			